WISCONSIN DVA VETERANS FORWARD | Wisconsin Department of Veterans Affairs

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (PREADMISSION)

☐ **WVH–Chippewa Falls**
**2175 E. Park Ave.**
**Chippewa Falls, WI 54729**
**(715) 720-6775 Fax (715) 720-6672**

☐ **WVH–King**
**N2665 County Rd. QQ**
**King, WI 54946-0600**
**Admissions:**
**(715) 258-5586**
**Fax (715) 256-3207**

☐ **WVH–Union Grove**
**21425 G Spring St.**
**Union Grove, WI 53182**
**Admissions:**
**(262) 878-6788**
**Fax (262) 878-6778**

**1.** I, _____ _____
Name Birth Date

**2. AUTHORIZES:**

_____
Name of Health Care Provider

_____
Street Address

_____
City, State, Zip Code

**3. RELEASE PROTECTED HEALTH INFORMATION TO:**

_____
Name

_____
Street Address

_____
City, State, Zip Code

**4. INFORMATION TO BE RELEASED:**

Dates of Service _____

☐ History and Physical
☐ Medication Sheets
☐ Consultations
☐ Other (specify): _____
☐ Discharge Summary
☐ Laboratory Reports
☐ X-ray Reports

In compliance with Wisconsin and Federal Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health
☐ Alcoholism
☐ HIV (AIDS)
☐ Other (specify): _____
☐ Developmental Disabilities
☐ Drug Abuse
☐ Sexually Transmitted Diseases
☐ Sickle Cell Anemia

FOR THE FOLLOWING DATE(S): _____

**5. PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)**

☐ Continuity of Care
☐ Insurance Eligibility/Benefits
☐ Other (specify): _____

**6.** This form authorizes release of information in accordance with Wis. Statutes 51.30, 252.15, and 146.81-146.84 and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and 38 U.S.C. 5701 and 7332.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**7. Your Rights with Respect to This Authorization**

- **Right to Receive Copy of This Authorization —** I understand that if I agree to sign this authorization, which I am not required to do, I have the right to ask to receive a signed copy of the form.
- **Right to Refuse to Sign This Authorization —** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Withdraw This Authorization —** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Admissions Office. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

**8. Expiration Date:** This authorization is good until the following date(s) _____ or event(s) (specify event) _____

A photocopied or faxed version of this authorization is as valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**9. Signatures:**

Member: _____ Date: _____

If an "X" is used: _____ Date: _____
Witnessed By

Legal Authority: _____ Date: _____

Legal Authority: ☐ Legal Guardian
☐ Executor of Estate of Deceased
☐ Activated Power of Attorney

Legal Authority Has Presented Documentation That Member Is:
☐ Legally Incompetent (Court Documents)
☐ Deceased (Death Certificate)
☐ Legally Incapacitated (appropriate documentation as required by law to activate Power of Attorney–Health Care)